Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY LIMITATION EXTENSION REQUEST

DATE

PROVIDER INFORMATION

PROVIDER NAME	BILLING PROVIDER NUMBER
TELEPHONE NUMBER	FAX NUMBER

CLIENT INFORMATION

CLIENT NAME	PIC NUMBER (AB-122300-SMITH-A)

ADDITIONAL THERAPY REQUEST INFORMATION

☐ PT – Number of units requested: _____ Number of units used this year: _____
☐ OT – Number of visits requested: _____ Number of visits used this year: _____
(2 units = 1 visit)
☐ ST – Number of visits requested: _____ Number of visits used this year: _____

CPT PROCEDURE CODES

ICD-9 Dx CODES AND DESCRIPTION

PLACE OF SERVICE: ☐ Outpatient Hospital ☐ Therapy Office

CLIENT'S MEDICAL HISTORY

DATE OF INJURY OR ILLNESS

DATE OF SURGERY AND DESCRIPTION:

What prevented the client from reaching the therapy goals with treatment provided to date?

List the functional improvement goals for the additional therapy requested:

Please attach the following to this request:

- Copy of prescription
- Letter with clinical justification
- Most recent therapy evaluation
- Therapy progress notes

Fax: 360-586-1471 or mail to: Medical Request Coordinator
HRSA
PO Box 45506
Olympia, WA 98504-5506